NOTE
The Department of Mental Health (DMH) materials added to the rulemaking file, as discussed below, were noticed to the interested parties, in accordance with Section 11346.8(d), Government Code for fifteen days beginning September 10, 2003 and ending September 24, 2003. (Documentation contained in the rulemaking file.)

Linda Croslin, Department of Developmental Services (DDS)

DDS Comment 1: "Depending on how the utilization controls are developed and implemented, there could be an impact to regional centers, as some individuals with developmental disabilities may no longer be deemed eligible for the mental health services or EPSDT (*Early and Periodic Screening, Diagnosis and Treatment*). Regional Centers may need to purchase services that were once covered by mental health or EPSDT. Or, providers of mental health services may decide to discontinue their business relationship with the MHPs (*mental health plans*) (Medi-Cal) and thus require regional centers to directly purchase the services through the provider.

The specific impact to regional centers is unknown as it depends on how the proposed utilization controls are developed and implemented, and how the providers conduct business under the utilization controls.

Response to DDS Comment 1: *DMH has determined that if MHPs and providers of mental health services have been appropriately applying the criteria for medical necessity as described at Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210, Medi-Cal beneficiaries receiving medically necessary mental health services would not have their mental health services discontinued. DMH will be monitoring the impact of the authorization requirements on the MHPs and their provider networks to determine if the requirement contributes to providers reducing or terminating contract services.*

DDS Comment 2: The Department of Developmental Services (DDS) concurs with DMH's rulemaking to prevent fraud and abuse in the Medi-Cal program and to increase effective management of the EPSDT program by the MHPs."

Response to DDS Comment 2: *DMH thanks DDS for acknowledging the DMH efforts to accomplish these goals.*

Maggie Roberts, Staff Attorney, Protection and Advocacy, Inc. (PAI)

PAI Comment 1a: DMH never filed the requirements it intends to implement via amendments to its contract with MHPs as a regulation with the Secretary of State.

Response to PAI Comment 1a:
DMH has included specific language in the FY 2003-04 DMH/MHP contracts, consistent with federal and state law, to ensure adequate compliance by each MHP. Utilizing contract language, rather than regulation, to establish specific provisions allows for administrative flexibility to address individual MHP issues. For example, DMH would be able to amend an individual MHP contract to establish different timelines if the standard timelines result in loss of access to medically necessary services for that MHP's beneficiaries. Such flexibility would not be available if the same level of specificity is established in regulation. DMH is including the FY 2003-04 DMH/MHP contract boilerplate in the rulemaking file; Exhibit A, Attachment 1, Sections Y and Z include the provisions related to MHP payment authorization of day treatment intensive, day rehabilitation and TBS.

PAI Comment 1b: DMH did not include **Information Notices 02-08 or 02-09** in its rulemaking file as reference.

Response to PAI Comment 1b:
DMH Information Notice No. 02-06, *dated October 1, 2002, describes proposed changes in requirements for day treatment intensive and day rehabilitation. DMH has added this Notice to the rulemaking file.*

DMH Information Notice No. 02-08 *dated November 8, 2002, describes proposed changes for therapeutic behavioral services (TBS) for reference as part of the rulemaking package. DMH originally intended to implement these changes by DMH/MHP contract amendments to be effective January 1, 2003. DMH* ***agrees*** *that this Notice should be included in the rulemaking file.*

DMH Information Notice No. 02-09 *dated December 2, 2002 provided notice of the DMH protocol for TBS chart reviews for a* ***previous fiscal year 2002-03*** *and does not pertain to this rulemaking effort. DMH does* ***not*** *agree this Notice should be included in the rulemaking file.*

DMH Information Notice No. 02-11, *dated December 30, 2002, provided notice that the changes described in DMH Information Notice Nos. 02-06 and 02-08 would not be implemented until after regulations were issued. DMH* ***agrees*** *this Notice should be included in the rulemaking file.*

PAI Comment 2: "This regulation is inconsistent with the purpose of the Administrative Procedure Act (hereafter the APA). Government Code §§ 11342 *et seq.* In fact, the amendment to the regulation appears to be an attempt on the part of DMH to circumvent the APA process. The amendment to the regulations essentially sets up a process whereby DMH can incorporate payment authorization requirements for TBS and other Medi-Cal mental health services through a contract with the MHPs. By doing so through a third-party contract, DMH deprives the public, including people who are directly affected by the new standards, of notice of DMH's new specific requirements for implementation of EPSDT supplemental specialty mental health services and other mental health services. It also fails to provide an opportunity for public hearing and comment on the standards and guidelines which are or will be incorporated in the DMH/MHP contract."

Response to PAI Comment 2: *DMH disagrees with the commenter. DMH included a detailed explanation of the reasons for including requirements in contract language in the Initial Statement of Reasons (ISOR). As stated in the ISOR, Welfare and Institutions Code Section 5777(c) provides that changes in an MHP's obligations* ***must be accomplished through contract amendment****. This requirement is consistent with federal requirements for medicaid managed care programs to operate under contracts between the State and the managed care entity, which is the MHP in the Medi-Cal managed mental health care program (see Title 42 Code of Federal Regulations (CFR), Part 438, commencing with Section 438.1). These federal medicaid managed care regulations include specific requirements for managed care plan authorization systems at Title 42, CFR, Section 438.210.*

This regulatory action (the amendment of Section 1830.215) establishes DMH authority to require MHP payment authorization of specific services. Based on this authority, DMH has included specific language in the FY 2003-04 DMH/MHP contracts, consistent with federal and state law, to ensure adequate compliance by each MHP. Utilizing contract language, rather than regulation, to establish specific provisions allows for administrative flexibility to address individual MHP issues. For example, DMH would be able to amend an individual MHP contract to establish different timelines if the standard timelines result in loss of access to medically necessary services for that MHP's beneficiaries. Such flexibility would not be available if the same level of specificity is established in regulation.

DMH is including the ***FY 2003-04 DMH/MHP contract boilerplate*** *in the rulemaking file; Exhibit A, Attachment 1, Sections Y and Z include the provisions related to MHP payment authorization of day treatment intensive, day rehabilitation and TBS.*

PAI Comment 3: "In order to meet the clarity standards of the APA, the standards contained in them must be written or displayed so that the meaning of the regulations will be easily understood by those persons directly affected by them. *See* Gov. Code § 11349(c). DMH has failed to write or display its standards for payment authorization so that they can be easily understood by the persons directly affected by them, including Medi-Cal beneficiaries and service providers. Indeed, this regulation is written in such a way that the substance of the intended standard changes are not described in the regulation at all, but are rather incorporated in a third party contract that is not readily available to the public, including Medi-Cal beneficiaries, their advocates, and service providers."

Response to PAI Comment 3: *As stated in the response to PAI Comment 2, specific terms of the MHP payment authorization process required by DMH must be provided via contract rather than regulation to allow for case-by-case changes to individual MHP contracts, particularly in the timelines for initial authorizations and reauthorizations. The regulation clearly establishes DMH authority to included MHP payment authorization requirements in DMH/MHP contracts.*

In addition, DMH worked with the California Mental Health Directors Association and other stakeholders, including Medi-Cal beneficiaries, family members, and providers, to obtain input on the proposed changes to content and authorization requirements for day treatment intensive, day rehabilitation and TBS. The regulation clearly indicates that the MHP payment authorization requirements established by DMH must be included in the DMH/MHP contracts. DMH/MHP contracts are available under the Public Records Act.

PAI Comment 4: "In order to meet the consistency standards of the APA, the standards must be "in harmony with, and not in conflict with or contradictory to, existing statutes, court decisions, or other provisions of law. *See* Gov. Code § 11349(c). There is an existing court decision and order which requires DHS and DMH to ensure that each MHP makes available a sufficient number of qualified TBS providers to meet its obligations to TBS class members in its jurisdiction, and that its class members otherwise have timely access to TBS. *See Emily Q v. Bonta* (C.D. Cal, 2001, CV 98-4181). Existing federal and state regulations also require the responsible state agencies to ensure reasonable access to EPSDT services. *See,* 42 C.F.R. § 441.61(b); (DHS is required to make available a variety of individual and group providers qualified and willing to provide EPSDT services.); C.C.R., title 9 §1830.225(a) (whenever feasible, an MHP shall provide EPSDT supplemental mental health beneficiaries with a choice of providers).

In making regulatory changes which would require MHPs to preauthorize the type, amount, and duration of certain Medi-Cal mental health services, including TBS services, DMH is not acting consistently or in harmony with the *Emily Q* decision or with existing federal and state regulations relating to ensuring consumer access to EPSDT mental health services.

According to the statements of many providers and county representatives who spoke to DMH representatives at the October, 2002 stakeholder's meeting, pre-authorization requirements will result in delays and gaps in the provision of TBS and otherwise restrict access to medically necessary TBS. Moreover, the specific guidelines which DMH described in its information notice 02-08 and which it apparently has promulgated through contract amendments are not consistent with the *Emily Q* decision. Particularly, the initial authorization threshold of 60 hours and the re-authorization threshold of 120 hours of TBS services create an unnecessary barrier to initial and continuous access to medically necessary TBS services. The heavy administrative burden of frequently re-evaluating and reauthorizing TBS creates a disincentive for counties to authorize TBS for more than a few hours a day, even if medically needed. Similarly, the heavy administrative burden involved in authorizing TBS for a fourth time under the amended DMH/MHP contracts creates a disincentive for counties to continue to re-authorize medically necessary TBS."

Response to PAI Comment 4: *DMH disagrees with the commenter. In adopting these regulations, DMH is not interfering in any way with the implementation of Emily Q. et al. v. Bontá (Case No. CV 98-4181 AHM, United States District Court, Central District of California). The Emily Q court order requires that identified Medi-Cal class members be assessed as to medical necessity for and have access to TBS. The court order is silent on the issue of MHP payment authorization. Existing federal and state regulations do require reasonable access to EPSDT services, but do not suspend federal and state regulations requiring the State to take action to monitor the Medi-Cal program adequately to prevent fraud and abuse.*

As PAI notes, providers and PAI did indicate their concerns about potential access problems in the stakeholder meeting in October 2002. MHPs, however, reported during the meeting that their existing authorization systems would have to be modified to meet the new requirements, but did not and have not indicated to date that the administrative burden was excessive enough to interfere with the delivery of medically necessary TBS. DMH believes that, contrary to the commenter's statements, these regulations should ensure that Medi-Cal beneficiaries in the classes specified in the lawsuit, who are properly entitled to receive medically necessary TBS, will receive TBS. As noted in the response to ***PAI Comment 2****, however, one of the reasons for including the specific authorization requirements in contract rather than regulation was to allow DMH to amend requirements if the MHP payment authorization process for day treatment intensive, day rehabilitation or TBS do result in loss of access to medically necessary services.*

Karyn Dresser, Director, STARS Behavioral Health Group

STARS Comment 1: "…have you conducted some baseline assessment of counties preparedness to implement and assume responsibility for the preauthorization process so as to ensure ease of access and quality of care and what are –what does the baseline look like?"

Response STARS Comment 1: *DMH did not conduct a baseline assessment of MHP preparedness to conduct pre-authorizations. All MHPs must have an MHP payment authorization system in place to meet the obligations for authorization of psychiatric inpatient hospital services as described in Title 9, CCR, Sections 1820.100 et seq., so the basic authorization system is not new to MHPs. DMH has also provided an effective date for the contract provisions authorized by the amendments to Title 9, CCR, Section 1830.215 that is 60 days from the July 1, 2003 effective date of the emergency regulations to allow MHPs time to ensure that any new systems were in place.*

STARS Comment 2: "…what methods are available for providers to redress sluggish, nonresponsive, or wrongly denied authorization or access to services?"

Response to STARS Comment 2: *Providers continue to have access to MHP provider problem resolution processes as described in Title 9, CCR, Section 1850.305. Providers may also assist beneficiaries to exercise their rights through the MHP beneficiary problem resolution processes required by Title 9, CCR, Section 1850.205 and through the Medi-Cal fair hearing process described in Title 22, CCR, Sections 50951 and 50953. Beneficiaries will receive a notice of action from the MHP if the MHP denies or modifies a provider's MHP payment authorization request or delays a decision on an authorization request beyond established timelines (see Title 9, CCR, Section 1850.210 for current notice of action requirements). Beneficiaries may designate a provider to act as the beneficiary's authorized representative in MHP beneficiary problem resolution processes or in Medi-Cal fair hearings.*

STARS Comment 3: "…how will you assess the results of the changes that you've implemented over time?"

Response to STARS Comment 3: *DMH will continue ongoing monitoring and evaluation through compliance reviews of the MHPs by DMH and through TBS chart reviews by DMH contractors. DMH will continue to monitor MHP reports on TBS providers and on the delivery of TBS that are components of a quarterly report from DMH to PAI required by the Emily Q court order. DMH will continue to monitor claims data from the MHPs on day treatment intensive, day rehabilitation and TBS. In addition, DMH has plans to survey MHPs during the first quarter of the implementation of the new requirements to assess the impact of the changes, i.e., between September 1, 2003, the effective date of relevant DMH/MHP contract provisions, and November 30, 2003.*